Psychopaths: Is a Therapeutic Community Therapeutic?

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ABSTRACT: A therapeutic community for psychopathic and non-psychopathic mentally disordered male offenders is described. The programme was humanistic, heavily peer operated, run by a charismatic leader, somewhat coercive, and employed radical therapeutic techniques. The programme was evaluated by comparing the post-release criminal and violent behaviour of men who participated in the programme with the outcome of matched control subjects who did not participate. Overall, the therapeutic community programme had a marginally positive effect on general recidivism and no effect on violent recidivism. However, whereas treated nonpsychopaths had lower recidivism rates than their untreated counterparts, the opposite was true for psychopaths. Possible explanations as to why a therapeutic community of this type may not be effective for psychopaths are discussed, as are suggestions for what treatments might work to reduce recidivism among psychopaths.

Introduction

To one who has never encountered individuals who may be described as classic psychopaths, the concept of psychopathy seems a slippery one. The historical terms moral insanity, moral imbecility, amorality, and more recent labels of sociopathy and antisocial personality disorder fail to add much illumination. Are such persons insane, imbecilic, or suffering from a personality or moral defect? The most obvious point to an experienced forensic clinician is that individuals so labelled actually suffer very little. It is true that psychopaths appear capable of a considerable depth of self pity. Unlike virtually every other mental disorder, however, where the existence of the problem is inferred from difficulties experienced by the patient, psychopathy is a disorder whose negative effects accrue more to those who come into contact with the psychopath than to the patient him or herself.

It is also clear that the concept of psychopathy has evolved. Cleckley (1976) described a group of individuals whose behaviour, though certainly callous,

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Therapeutic Communities (1994), Vol 15 No 4

manipulative and antisocial, was not especially sinister or dangerous. Cleckley further asserted that few psychopaths commit serious felonies. Indeed, much of the troublesome behaviour described by Cleckley seems to be simply disorganised and reminds us of some of the features of what DSM-III-R calls borderline personality disorder (American Psychiatric Association, 1987). By contrast, the definition of antisocial personality disorder in DSM-III-R presents the clinical picture of somewhat more purposeful and destructive antisocial behaviour.

Our own views of the disorder have also changed since we began our study. When we first had the idea to study the treatment of psychopaths in the early 1980s, we were highly sceptical about the existence of psychopathy, believing that it was virtually synonymous with "having a lengthy criminal history." The results we report later in this chapter have begun to change our minds. Clearly, there is mounting evidence that psychopaths are different from other people in ways more fundamental than simply having exhibited more antisocial behaviour.

Although, not surprisingly, persons labelled psychopaths occupy much of the space in correctional institutions. Clearly, because of its great social cost, an effective treatment (or prevention, of course) for such a serious disorder should have very high priority. What kind of treatment ought to change the salient characteristics of psychopathy? What could alter the callousness, unreliability, insincerity, poor judgment, impulsivity, pathological lying, selfishness, lack of remorse, lack of empathy, instability, rejection of authority, disregard for social convention and, of course, persistent antisocial behaviour of psychopaths? The most obvious and clinically defensible answer to such questions now and 30 years ago is to place such individuals in an environment where psychopathic behaviour is essentially impossible—a carefully constructed environment where there are no secrets; where success and even survival demands responsibility, caring for others, delay of gratification, honesty, generosity, stability and obedience. What must be required is a total institution where psychopaths can learn such virtues in order to rejoin a society that failed to teach them in the first place.

The following is a description of a therapeutic community established in the 1960s at the maximum security Oak Ridge Division of the Mental Health Centre in Penetanguishene, Ontario designed to effect changes in the personalities of psychopaths.[1] There is no doubt that the therapeutic community we describe was based on sound clinical experience and a solid theoretical understanding of the contemporary literature on the treatment of criminal offenders. Following a description of the therapeutic community, we describe our own retrospective evaluation of the programme.

The Social Therapy Unit

Although therapeutic communities had been employed in treating mental patients much earlier (Fairweather, 1964; Jones, 1953), the novel approach employed at Oak

[1]Clearly the programme's innovators were not working with a modern definition of psychopath such as that provided by Hare. It is clear that the programme's innovators hoped it would be effective with all offenders including psychopaths.

Ridge had its roots in the early 1960s. Impressed by accounts of the evils of brainwashing during the Korean War, the Unit's clinical leaders determined that the use of an environment in which control was exerted over patients' intellectual, emotional and spiritual life could be used to accomplish great good (E.T. Barker, personal communication, 1985). In September, 1965 the therapeutic community programme was born on one Oak Ridge ward and by 1968 had spread to four wards housing approximately 150 patients.

Much has been written about the Social Therapy Unit or STU (Barker & Mason, 1968a; 1968b; Mason, 1967; Barker, 1980; Barker & McLaughlin, 1977; Harris *et al*, 1991; Rice *et al.*, 1992; Canada, 1977; Quinsey, 1981; Weisman, in press). It is also fair to say that a definition of therapeutic community is elusive. Unlike behaviour therapy or even psychoanalysis where there exist large explicit literatures on the defining properties of the therapies, therapeutic communities vary greatly in their philosophical orientation, therapeutic techniques, the role of staff, and characteristics of the clientele (DeLeon, 1984; Ogloff, Wong & Greenwood, 1990; Toch, 1980). We each observed the programme as clinicians working on another Oak Ridge Unit during the programme's latter days. Consequently, it is difficult to know exactly what to report about it. However, the following is a list of those characteristics we believe are central to understanding how the programme had its effects on those who participated in it.

Humanistic. Patients spent a great deal of time in groups, dyads and triads where the goal was to strip away society's influences and achieve true communication and reveal participants' essential nature. It was assumed that only in this way could dangerous men be made safe. The writing of Martin Buber strongly influenced the programme's innovators: "Each of us is encased in armour which we soon . . . no longer notice. There are moments which penetrate it, and stir the soul to sensibility." (Buber, 1961 quoted in Barker & Mason, 1968b). Indeed, the intense exploration of subjective experience and personal values extended to the use of nude marathon encounter sessions in the "total encounter capsule"—a tiny self-contained chamber where sustenance was supplied through tubes in the walls and from which no group members would leave during sessions that lasted up to two weeks (Barker and McLaughlin, 1977). In all, patients in the therapeutic community spent an astounding amount of time and effort aimed at discovering who they were, how they affected others and how they could be otherwise.

It is worth noting, too, that little effort was expended in organised recreational programmes. Very few patients participated in academic upgrading or vocational training. Some patients worked in contract workshops, in the kitchen or on cleaning crews. However, such work was regarded as a temporary "rest" from therapy and such patients shared the wages they earned with the patients involved in intensive therapy. No programmes were specifically aimed at altering procriminal attitudes and beliefs, teaching social skills or social problem solving, or training in life skills. A small proportion of the patients were diagnosed as psychotic and were prescribed neuroleptic

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drugs, but efforts were made to keep doses as low as possible. It was felt that, for psychopaths, an important positive feature of the programme was that it gave them an opportunity to care for the psychotic patients.

Peer Operated. It was a fundamental assumption of the programme that patients had to be the agents of change for each other. The programme's innovators believed that therapeutic change was much more likely without professional therapists, and therefore kept the numbers of professional staff as low as was ethically and bureaucratically possible. Patients who showed clinical progress and talent were given leadership roles in the therapeutic community. However, the programme's innovators were not naive about the dangers here:

> The other problem was the phenomenon of patients, usually psychopaths, rising to the organisational apex of a therapeutic community without themselves being touched by the programme. Glib, articulate, and well versed in the defensive 'psychologese' that can cover the most radical conflicts by describing them impressively, they had become accustomed to operating with a minimum of discomfort in the highly structured programmes (Barker & McLaughlin, 1977; p.356).

Charismatic. The successful implementation and functioning of the programme was due primarily to the personal qualities of its innovators. Without doubt, it was the force of his convictions as well as his political and interpersonal acumen that enabled Barker to establish the Social Therapy Unit. Barker's skillful management of a number of powerful competing forces to remodel an extremely authoritarian and custodial institution are legendary at Oak Ridge. Although his interpersonal style was quite different, G.M. Maier, who succeeded Barker in 1973, was personally involved in every aspect of the programme. These facts are crucial because it is important to note that it was largely through the force of the Unit Directors' personalities that the therapeutic community achieved an enviable degree of programme integrity. The programme was a "total experience" (Barker and Mason, 1968a; Barker and McLaughlin, 1977) and there can be no doubt that, unlike many therapy programmes in mental health and corrections, it operated very much as it was intended and described (Weisman, in press).

Coercive. Barker wrote unashamedly that the Social Therapy Unit employed coercion (Barker & Mason, 1968a; b). However, in understanding the results we obtained, it is important to examine this assertion about coercion carefully. The programme was coercive in that entry to, and participation in, the STU programme was not voluntary and stated willingness was not a selection criterion. Thus, a man found not guilty by reason of insanity or convicted of violent crime and then civilly committed could be assigned to the programme even if he did not wish to be. Once in the programme, patients who refused to engage in detailed discussion of their offenses,

backgrounds and feelings were sent to a subprogramme where they discussed their motivation, attitudes, and participation until they complied with programme requirements (only a third of the patients experienced more than one visit to this subprogramme, however). While patients could leave the therapeutic community by convincing staff or an independent review board that they had made clinical progress, they could not get out simply by misbehaving. Noncompliance and disruption were regarded as symptoms to be changed and this form of attrition was not permitted. There were several aspects of the programme that might be seen to violate patients' rights by today's standards, but the programme was very favourably reviewed on both ethical and clinical grounds at the time (Butler *et al.*, 1977; Canada, 1977)

> To what extent is force legitimate in treating patients who are incarcerated because of illnesses that they do not recognise, or for which they wish to receive no treatment? We think that when one is confronted with such persons, one must first decide if such imprisonment is warranted and if it is not, the task is to 'treat' society rather than the patient. But in situations where patients are quite properly being held against their will until they change, it seems humane and helpful to use force, at least to the point of increasing their range of choice, of increasing their awareness of themselves, and others, to the point where, as far as can be determined, what they do, they self-consciously choose to do. The validity of force depends on this assumption.
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> Our patients did not choose to deviate from society's norms, but rather were driven to such deviations by internal unresolved conflicts. Then we should help them to resolve such conflicts by every means at our disposal, including force, humiliation, and deprivation, if necessary.
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> In our opinion, there is no question that the treatment necessary to produce some remission of the illness suffered by most Oak Ridge patients would be impossible on a voluntary basis.
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> It may be that the effect of force depends upon the motivation for its use, the way in which the motivation is conveyed from the agent to the patient, and the way in which it is perceived by the patient. If communication is maximised, coercion may be therapeutic, particularly when it is exerted by peers rather than authority figures. Our feeling was that force could most usefully be employed in treatment, particularly the treatment of the asocial and antisocial personality disorders; and that as communication approaches a maximum, the permissible use of force also approaches a maximum (Barker and Mason, 1968b; pp.64-65).

In addition, very tight perimeter and internal security was maintained by patient leaders and attendants. Here the clinical leaders permitted considerable latitude to the attendants in enforcing security. Increases in various security precautions were conceded to the attendants in order to achieve new programme innovations. In disputes with patients, attendants were supported unconditionally (except for contraventions of

the rules of conduct). Key attendants had *de facto* veto power over administrative decisions (Barker, 1980)

We believe that the programme relied almost entirely on the total environment and on psychological influence to achieve compliance with programme requirements. Much less often was it necessary for programme leaders to employ sanctions and punishments for undesirable conduct. Clearly, too, there was a distinct limit to the use of coercion. We believe it is fair to say that legitimised coercion was not permitted to subvert or corrupt the therapeutic integrity of the STU programme. Perhaps the best evidence for this came from the sudden demise of the programme itself in 1978. Under the guise of authority over security, militant attendants and the STU's clinical directors became locked in a political dispute over ultimate control of the programme. The clinicians refused to compromise their principles, lost the political struggle and were all immediately and permanently banished from Oak Ridge. The importance of this incident lies in the fact that, for the programme directors, clinical considerations were of supreme importance.

Radical. Although therapeutic communities have existed elsewhere, the STU was unique in its use of radical therapeutic techniques. Some have been described above. In addition, there was some reliance placed on defense disrupting therapy (DDT). At various times, methedrine, LSD, scopolamine and alcohol were all used alone or in combination to "loosen the rigidly implanted patterns of behaviour behind which many hide the turmoil of their disorders" (Barker, Mason and Wilson, 1969). The most important effect of the drugs (especially methedrine-scopolamine combination) occurred in the weeks after administration and produced restlessness, nervousness, hypersensitivity and anxiety that in turn appeared to lower patients' defenses and "spur them to examine their assumptions about themselves and the world" (Barker *et al*, 1969; p.357). Indeed, it seemed that such drugs directly attacked some psychopathic characteristics:

> Patients who have a solid background in the inmate subculture tend to undermine subtly or attack violently the principles of free communication upon which the therapeutic community depends, and their persuasive glibness or numbing hostility is profitably fragmented by DDT. As a rule they emerge from the experience with their aggressiveness considerably diluted. What is more, they are also anxious and therefore considerably more accessible to treatment than had they been managed with large doses of a tranquilliser or seclusion, both of which have the two-fold disadvantage of making them a management problem and halting their involvement in the programme.
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> DDT also gives a marked advantage to the psychopath who in our treatment setting must continue to live with the same group of people after they get 'on' to him. When forced to continue living with the same persons, the initial attractiveness of these patients sours quickly to an acid savagery that wards off potentially helpful encounters. Most patients find it is easier to develop

> concern for the psychopath when he is chemically cooled out and dependent, than when he is 'normal' and coldly aloof (Barker *et al*., 1969; p.358).

Thus the programme innovators showed a remarkable understanding of the core characteristics of psychopathy. They showed considerable ingenuity and professional courage in their attempts to alter the important characteristics of psychopaths. In our view, the programme initiated in 1965 is, to this day, unmatched in integrity, intensity and innovation for programmes of this type. Indeed, in March, 1991, at a Correctional Service of Canada sponsored conference with international experts convened specifically to recommend innovative and promising therapies, many features of the STU programme were offered as "new" ideas for the treatment of psychopaths.

Evaluating the Therapeutic Community

Long impressed by many features of the programme, we finally had the opportunity to conduct a careful study in the late 1980's. We decided to study the criminal recidivism of every patient who participated in the programme during the period that it encompassed four Oak Ridge wards (1968 to 1978). We decided to consider only those patients who had spent at least 2 years in intensive treatment on the STU. The evaluation is described in detail elsewhere (Harris *et al*., 1991; Rice *et al*., 1992). Here we provide only a summary of the method and results.

Method

The key to our retrospective evaluation was the use of a matched sample design. During the STU's period of most active operation, Oak Ridge provided many pre-trial psychiatric assessments annually. The purpose of such an assessment was to comment on fitness for trial, suitability for bail, and applicability of the insanity defense. Most assessment (remand) patients never returned for treatment and it was from this large pool of untreated men that we drew our comparison sample.

To permit a fair comparison, each pair of subjects (one treated matched to one untreated) had to exhibit equivalent pre-treatment risk of criminal recidivism. Then, if overall differences in recidivism were observed, they could be attributed to the therapy versus incarceration difference. Thus, the matching procedure was based on those personal characteristics most commonly associated with criminal recidivism among males: age, criminal history, and index criminal offense (Gottfredson, 1967; Nuffield, 1982; Simon, 1971).

The matching criteria were: (a) the same age within 1 year at the time of the index offense, (b) charged with the same index offense, (c) equivalence in criminal history for each of property and violent offenses according to our adaptation of a system developed by Akman and Normandeau (1967), and (d) charged with their index offenses no more than 2 years apart. In addition, comparison subjects could not have

returned to the study institution for any treatment. Almost all (84%) comparison subjects spent some time in a correctional institution (Mean=50.7 mo, *SD*=46.4). Virtually all of the subjects (over 90%) had committed at least one violent offense either as the index offense, or as part of their previous offense history.

A second important feature of our study had to do with the way in which we determined recidivism. Recidivism data were obtained from a variety of sources including the files of the Coroner's Office, the Lieutenant Governor's Review Board, the Royal Canadian Mounted Police (a national fingerprint data base including INTERPOL reports), the National Parole Service of Canada, and provincial correctional and parole systems. In order to prevent inadvertent contamination of the historical variables by raters' knowledge of outcome, childhood history, adult adjustment, offense and assessment variables were coded using only file information at the time the subject entered the programme or was initially assessed, and outcome data were obtained only after all other variables had been coded. Details on the coding of all other study variables can be found in Harris *et al.*, (1991).

Subjects were classified as failures if they had incurred any new charge for a criminal offense, or had their parole revoked or were returned to the maximum security institution for behaviour that could have, in the judgment of the research assistants, resulted in a criminal charge. Violent failure comprised any new charge against persons, or any parole revocation or return to the maximum security institution for violent behaviour.

It is important to note at this point that (as with any disorder) progress in understanding psychopathy depends on the reliability and validity with which it can be measured. There is little doubt that until about 10 years ago, adequate classification criteria for psychopathy were lacking (Ulett, 1972). Although there is some agreement about the characteristics of psychopathy (and the closely related term antisocial personality), it is difficult to evaluate evidence linking psychopathy and crime because criminality is a defining characteristic of psychopathy (American Psychiatric Association, 1980; Hare, 1970; 1986). Although it contains some items related to criminal history, the 20-item revised Psychopathy Checklist is the best available operationalisation of psychopathy in offender populations (Hare, 1980; 1985; 1986; Hare *et al.* 1991; Schroeder *et al.*, 1983). The PCL-R correlates highly with Cleckley's (1976) criteria and DSM-III diagnosis of antisocial personality disorder (Hare, 1983; 1985). Consequently, we used the PCL-R, based on retrospective coding of detailed clinical information, as our operationalisation of psychopathy. Thus, for the purposes of the comparisons described below, subjects who received a score of at least 25 on the PCL-R, whether treated or not, were declared psychopaths while all others were declared non-psychopaths.[2]

[2]Our subsequent work has shown that this criterion was very conservative in that there were probably very few "true" nonpsychopaths among the subjects declared to be psychopaths, while there were probably several "true" psychopaths among the subjects declared to be nonpsychopaths (Harris *et al.*, 1994).

The matching procedure was remarkably successful in that it resulted in two groups of equal age, criminal history and index offense. In addition, the two groups were indistinguishable on a large number of childhood history, adult adjustment, index offense and assessment variables (approximately 50 were coded with acceptable interrater reliability). Probably the only important difference between the two groups was psychiatric diagnosis, such that the treated group comprised of more psychotic individuals. Interestingly, the proportion of psychopaths (as defined by the PCL-R) was the same in both groups. Of course, the interrelation of diagnosis and treatment formed the crucial result of the study.

As final methodological points, it is important to note first, that the groups did not differ in the duration of the follow up period. Second, we also compared the treated and untreated psychopaths alone. Again, the matching procedure had been highly successful with perhaps a slightly higher level of risk of recidivism for the untreated psychopaths. Third, there were only a few psychopaths who were matched to psychopaths (14 pairs), but subsidiary analyses showed that the same effect of treatment described below was obtained for these subjects as well.

Results of the Evaluation

Overall, the programme had a small effect on recidivism. General criminal recidivism and violent recidivism were 59% and 40% for the matched treated subjects, and 68% and 46%, respectively for their yokes. The result for general recidivism yielded a marginally statistically significant effect (x^2 (1, N=280) = 2.86, $p<.10$). However, the differential results for psychopaths and nonpsychopaths separately were much more striking. First, for general recidivism, almost all psychopaths failed (87% for treated subjects and 90% for untreated), but fewer treated nonpsychopaths failed (44% versus 58%. x^2 (1, N=206) = 3.87, $p<.05$). For violent recidivism, there was a very powerful and surprising interaction of treatment and psychopathy shown in Figure 1. It should be noted that the differences between treated and untreated subjects were statistically significant for *both* psychopaths and nonpsychopaths. We also conducted subsidiary analyses to ensure our surprising results were not due to some artifact inherent in our design. That is, we showed that the positive effect of the programme occurred for psychotic subjects and for nonpsychotic subjects as long as they were not psychopaths. In addition, the negative effect of the programme on psychopeths occurred whether or not they were also psychotic.

The final analyses concerned variables specific to the treatment programme. These were variables that pertained at least in a general way to the patient's adjustment to the institution, his success in the programme, and the degree to which he was trusted by the programme's clinical staff. The interesting comparisons involved the ways in which psychopaths and nonpsychopaths differed. Psychopaths showed much poorer adjustment, assessed in terms of problem behaviours, both in their first year and in their last year. However, when variables that reflect the degree of trust by clinical leaders are considered, psychopaths and nonpsychopaths showed no differences.

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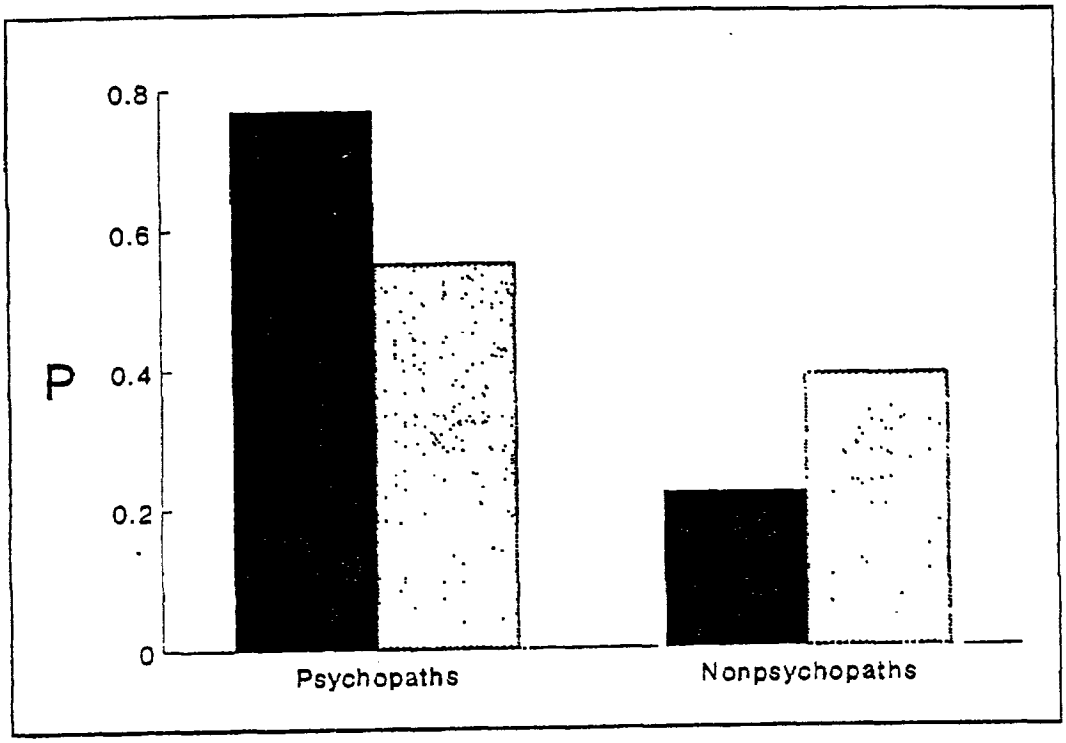
Figure 1: The probability of violent recidivism (P) as a function of psychopathy for subjects treated (solid bars) or untreated (hatched bars) in a therapeutic community



Interestingly, the first set of variables, reflecting patient's behaviour rather than staff trust, were consistently related to recidivism.

In the end, we were convinced that our retrospective evaluation comprised two very equally matched groups of serious offenders, one of whom participated in the STU therapeutic community and one of whom did not (the vast majority of this latter group were incarcerated). Subsidiary analyses showed that our surprising results were due neither to the presence of psychotics in the treated group nor to any pre-existing differences between the two groups of psychopaths nor to any other confounder or artifact in our design. Thus, if the interaction shown in Figure 1 is not a spurious finding (and that of course is highly unlikely, $p<.002$), there must have been a differential effect of treatment (therapeutic community *versus* prison) upon the subjects (psychopaths *versus* nonpsychopaths). The next section explores possible explanations for this surprising result and speculates about implications for the treatment of psychopathy.

Discussion

Considering all subjects together, the therapeutic community described in this paper, compared to prison, had no effect (or, at best, very modest effect) on the recidivism of

violent offenders. Given the amount of effort that was put into the development of such a highly intensive, carefully structured programme, this was a very disappointing result. However, the results were in accord with the lack of positive effects on the recidivism of high risk populations in other carefully evaluated therapeutic community programmes (Gunn and Robertson, 1982). Indeed, we are not the first to suggest that therapeutic community treatment is contraindicated for psychopaths. After evaluating the therapeutic community at Britain's Henderson Hospital, Whiteley (1970) concluded that the programme, "... is of less benefit and could be harmful to the more immature, persistently acting-out psychopath ('inadequate psychopath'), and it is doubtful if it can be of benefit to the totally egocentric, impulsive, thought-disordered and primitive personality ('aggressive psychopath')" (p.527). In fact, a recent meta-analysis of treatment in correctional samples showed that treatment can work, but only appropriate treatment, and therapeutic communities and other programmes where communication with peers was emphasised were not among the appropriate treatments (Andrews *et al.*, 1990).

The most important result of the present study, however, was the finding that, compared to prison, the therapeutic community had a positive effect (in terms of reducing violent recidivism) for the nonpsychopaths and a negative effect for the psychopaths.[3] What might explain these results?

First, why did the psychopaths have higher rates of violent recidivism after participation in the therapeutic community than they did after spending time in prison? One possibility is that psychopathic patients in the therapeutic community learned different things compared to the psychopaths in prison. Specifically, one might speculate that psychopaths in prison engage in discussion about such things as how to avoid detection when committing offenses. By this account, upon release, they committed offenses at an equally high rate as before, but they were less likely to be detected.

On the other hand, we speculate that psychopaths in the therapeutic community may have learned to be more self-confident criminals who could maintain high self-esteem whilst committing antisocial acts. However, because they had not learned how to avoid detection, they were more likely to be caught (and perhaps even committed more offenses) than psychopaths who went to prison. Support for this view comes from data that showed that the psychopaths, while no different from the nonpsychopaths in terms of many aspects of their behaviour in the programme, were more likely to be placed in positions of trust and to be given leadership roles. In addition, a study done during the time period of this evaluation of the therapeutic community showed that the goals selected by and for patients to work on during their time in the programme included becoming more expressive, more trusting of others, more popular and more assertive (Quinsey and Harris, 1974). As Andrews *et al.* (1990) point out, "neurotic misery and overcontrol are not criminogenic problems for a

[3]A subsequent check on the recidivism of the psychopaths has shown that the rate of violent reoffenses is even higher than that reported here.

majority of offenders" (p.376) and, we would add, especially for psychopaths. Thus, evocative and relationship-dependent psychodynamic or humanistic approaches that are designed to free clients from overactive superegos are simply the wrong type of treatment for psychopaths because psychopaths simply gain new tools to exploit the good will of others.

On the other hand, the nonpsychopaths who participated in the programme had lower rates of violent recidivism upon release relative to their counterparts who went to prison. Why might that have been? We speculate that nonpsychopaths who went to prison were exposed to high levels of modelling of antisocial values and criminal attitudes that led them to commit more serious and more violent crimes after release. On the other hand, nonpsychopaths in the therapeutic community profited from the experience in terms of learning responsibility for themselves and others, learning to empathize, and how to discuss their feelings and problems with others. Moreover, the therapeutic community actively discouraged the promotion of procriminal attitudes and values that we speculate were very damaging for nonpsychopaths in prison. Thus, we believe it is possible that whereas prison actually harmed the nonpsychopaths, participation in the therapeutic community changed them in ways that reduced their likelihood of recidivism.

Why do we speculate that the nonpsychopaths profited from the therapeutic community by becoming more empathic while the psychopaths did not? Becoming more empathic was a common goal for patients in the therapeutic community (Quinsey and Harris, 1974). It has been suggested (Chlopan *et al.*, 1985) that there are two aspects of empathy. One is largely cognitive and is closely akin to perspective-taking; that is, being able to see things from the perspective of another. The other aspect of empathy is more emotional: it involves actually *feeling* the same feelings as the other. For reasons we will outline below, we speculate that psychopaths are quite capable of learning the cognitive aspects of empathy, but are very poor at learning the emotional aspects. And, we argue, it is the emotional aspects of empathy that forces one to feel what a victim would feel and thus can inhibit one from inflicting pain or harm upon another.

Many of the characteristics of psychopaths appear to be related to an "affective" deficit. Hare and his colleagues (Hare *et al.*, 1991) have conducted studies in which they have demonstrated that, compared to nonpsychopaths, psychopaths tend to associate words on the basis of their denotative (or literal), rather than connotative (or emotional) meanings. As Cleckley (1976) pointed out, psychopaths can learn to pantomime feelings of others but they don't truly feel them. We speculate that psychopaths in the therapeutic community spent a lot of time learning how non-psychopaths would feel in certain situations and how to mimic those feelings. But they did not, and perhaps could not, experience the feelings themselves.

We spent considerable time at the beginning of this chapter explaining the details of this particular therapeutic community programme. We did this because we believe that the programme was very carefully designed and conscientiously implemented as described. At the same time, the programme ran for over a decade, and it did, as

described earlier, undergo some changes during that time. Because the therapeutic community during the first half of our study period was probably somewhat less controversial and less politicised than the programme during the latter half (Weisman, personal communication, 1992), we examined whether there was any evidence that the earlier programme graduates fared better upon release than later graduates. Unfortunately, we could find no evidence that this was the case. What we found, in fact, was a trend for the interaction effect to be even stronger for earlier than later graduates. That is, there was a trend for psychopaths treated in the early years of the programme to do worse, and for nonpsychopaths to do better, than their counterparts who entered the programme in its later years. Our data suggested, then, that the more true the therapeutic community to the ideas of democracy, egalitarianism, and honest and open communication, the stronger its effects (both negative and positive).

Our data force us to the conclusion that the therapeutic community described in this paper was not the treatment of choice for psychopaths. Was it the treatment of choice for the nonpsychopaths? We found that, compared to those who went to prison, the nonpsychopaths in the therapeutic community had a lower rate of general and violent recidivism. Of course, this result could have been obtained as the result of prison making nonpsychopaths more likely to recidivate compared to no programme, or to the therapeutic community making them less likely to recidivate, or both. We have already suggested ways in which both of these explanations could be true. Even if the therapeutic community was a beneficial programme for nonpsychopaths however, we point out that it may not necessarily have been an ideal programme for nonpsychopaths. Andrews *et al.* (1990) have argued that programmes that reduce criminal recidivism focus directly upon criminogenic factors. In fact, based on their review of the literature, we might expect that programmes which focussed on skill enhancement and cognitive change would have produced faster and perhaps greater reductions in recidivism.

Another explanation of the present positive findings among nonpsychopaths in the therapeutic community has nothing to do with the difference between prison and the therapeutic community programme but rather with different levels of post-release supervision in the two groups. Most men sent to prison were on parole for time-limited (and short) periods after release, and parole supervision is often minimal in any event. However, most of the treated nonpsychopaths were men who had been found not guilty by reason of insanity and were subject to indeterminate periods of supervision as laid out under their "Warrants of the Lieutenant Governor." These warrants in most cases specified that they continue to receive treatment, and often specified conditions such as that they must refrain from the use of alcohol, and live in a particular place for many years following their release from custody.

In order to determine whether this explanation fit our data, we reexamined our results to see whether the men found not guilty by reason of insanity (and who thus received greater supervision than other patients) were less likely to reoffend than the other treated nonpsychopaths. We found that the data provided support for this explanation. Whereas 30 out of 77 (39%) of the nonpsychopaths found not guilty by

reason of insanity reoffended, 21 of 39 (54%) of the other treated nonpsychopaths reoffended. The latter rate was similar to the 58% reoffense rate of untreated nonpsychopaths. Similar results were found for violent recidivism where only 16% of the nonpsychopaths who had been found not guilty by reason of insanity reoffended, compared to 33% of the other treated nonpsychopaths and 39% of the untreated nonpsychopaths. Of course, there may have been other differences between the nonpsychopaths found not guilty by reason of insanity and the other nonpsychopaths (Rice and Harris, 1990) that could also account for the differences, but nevertheless, the results are consistent with the idea that the extra post-release supervision was important in reducing the recidivism of the treated nonpsychopaths.

The standard for the credibility of scientific findings lies in their repeatability. Consequently, it is worthwhile considering possible opportunities for the replication of the findings we have reported here. Because of its demise, there is no chance to perform another evaluation of the same programme. Because of modern views of personal liberty and the importance of consent, setting up a similar programme today would be extremely difficult, even if a clinician were interested. In fact, in modern therapeutic communities, psychopaths are more likely than other participants to be ejected or drop out, making evaluation extremely difficult (Copas *et al.*, 1984; Ogloff *et al.*, 1990). However, there have been, and continue to be, many therapy programmes for offenders that concentrate on insight and improving self esteem. Despite suggestions to the contrary (Copas *et al.*, 1984), we speculate that, compared to no treatment, such therapy would have little effect on recidivism, and among psychopathic offenders, such therapy might even be associated with significantly higher rates of criminal recidivism (Andrews *et al.*, 1990). Furthermore, therapeutic communities remain very popular for the treatment of substance abuse. We would speculate further that, compared to other treatment or even no treatment, clients who exhibit psychopathic characteristics would be less successful (exhibit higher relapse) after participation in a therapeutic community that embodied a psychodynamic or humanistic orientation.[4]

What sort of treatment programme might work for the psychopathic offenders? Unfortunately, our research is not a great deal of help in suggesting what treatment for psychopaths *ought* to be like. However, we might be able to get some clues by looking at which variables in our study were correlated with violent recidivism. We found (Harris *et al.*, 1991) that, in addition to criminal history variables (which, of course, cannot be changed with treatment), there were some variables that were potentially changeable with treatment that were related to recidivism. One of these had to do with alcohol abuse. Subjects with more serious histories of alcohol abuse had more violent recidivism. Another had to do with criminal attitudes—the more a subject endorsed procriminal values and attitudes, the more likely he was to recidivate. These factors are exactly the sort of dynamic risk factors or criminogenic needs that, if they could be

[4]Because of the greater likelihood that psychopaths would be drop-outs, it would, of course, be imperative to evaluate the recidivism or relapse of all participants—not just those subjects who completed the treatment.

changed, could reasonably be expected to lower the rate of violent recidivism (Andrews *et al.*, 1990). Thus, we would propose that a treatment programme for psychopaths carefully assess each offender for his criminogenic needs, and then design a treatment programme to address those needs. Common targets would include changing antisocial attitudes, increasing self-control, reducing chemical dependencies, and replacing the skills of lying and aggression with more prosocial skills. Although neither we nor others can provide any encouraging data regarding the use of these techniques with psychopaths, at the very least, we can say that they are important targets. There are as yet, to our knowledge, no data to argue against the idea that an attempt to alter these, that was as carefully planned and as conscientiously implemented as was the therapeutic community described in this paper can be successful in ultimately reducing criminal recidivism.

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SAMENVATTING: Beschreven wordt een therapeutische gemeenschap voor psychisch gestoorde manlijke delinquenten met een psychopatische en niet-psychopatische structuur. Het behandelprogramma was humanistisch-psychologisch, met veel groepswerk, een charismatische leider, enige dwang, en met drastische therapeutische methoden. Het programma werd geëvalueerd door crimineel en gewelddadig gedrag van deelnemers na ontslag te vergelijken met dat van een controlegroep die niet had deelgenomen. Globaal gezien had het therapeutische-gemeenschapsprogramma een marginaal positief effect op de algehele recidive, en geen enkel effect op een gewelds-recidive. De behandelde niet-psychopaten recidiveerden minder dan de onbehandelde controlegroep, terwijl het tegenovergestelde gold voor de psychopaten. Er wordt ingegaan op mogelijke verklaringen van het gebrek aan succes van een therapeutische gemeenschap van dit type bij psychopaten. Ook worden suggesties gedaan voor welke behandelingsvormen de recidive bij psychopaten dan wel zouden kunnen terugdringen.